

Centers for Medicare & Medicaid Services (CMS)

Merit-Based Incentive Payment System (MIPS) Overview: Understanding Advancing Care Information (ACI) & Improvement Activities

Held on December 13, 2017

>> Ladies and gentlemen, this is the operator. Today's conference is scheduled to begin momentarily. Until that time, your lines will again be placed on music hold. Thank you for your patience.

>> Hello, and thank you for joining today's CMS and MIPS overview presentation on "Understanding Advancing Care Information and Improvement Activities." Today you will hear from CMS subject-matter experts Ashley Spence, Elizabeth Holland, Angela Foster, and Alexandra Muggle. These experts will provide an overview of the "Advancing Care Information and Improvement Activities" performance categories of MIPS. Questions will be taken at the end of the presentation via the chat box. The questions and answers will be read aloud for everyone to hear. The speakers will get through as many questions as time allows. If your question is not answered during the webinar, please contact the Quality Payment Program's Service Center at gpp@cms.hhs.gov. I would now like to introduce Ashley Spence, health-insurance specialist, who will provide the introduction to today's training session. Ashley, you may begin.

>> Thank you. And good afternoon, everyone. So, this is Ashley Spence, and I am a health-insurance specialist here at CMS. So, welcome to the webinar today. We're going to focus on "Advancing Care Information and Improvement Activities Performance Categories," which are both a part of the Merit-based Incentive Payment System. Just a caveat, as we go through the presentation, is that we focus primarily on these performance categories for this presentation, but we did have an overview presentation for MIPS in general, as well as the Quality Payment Program. And so those presentations are available for you. And you can get to them via the Quality Payment Program website, and that's qpp.cms.gov. If you click on "Education and Tools," you can get to all of the past webinars.

I would also like to inform you that we are polling participants because what we really need is an understanding of your comfort level. So, before we present and after, you will see a poll. And it should be popping up any second now for you. And we would ask that you answer honestly how confident you are in your understanding of these performance categories. And then, at the end of the presentation, we'll ask the same question. These questions help us to tailor the information and the way that we present it for future presentations, as well as other educational resources. So we ask that you, again, answer, please, please, please. And it really does help us for future education outreach.

Next slide, please. So, the next slide here just sets the agenda for today. So, we will focus on... Are we on the next slide?

Just one moment.

All right. Sorry, I don't have the next slide up. So, the next slide presents the agenda. We're going to provide a brief overview of the Merit-based Incentive Payment System, as well as jump right into the performance categories. And so we'll provide you with an overview of those two, and then we'll also talk a little bit about scoring and what's next for the two performance categories. Just also another kind of tidbit is, if you continue to watch the Quality Payment Program website at the link that I gave

you, you'll also see links, in the next week or two that will announce the webinars for other performance categories for MIPS. There will be a Q&A session to follow this presentation, as well as, toward the end of the presentation, we will provide you with resources if you have questions that we aren't able to get to. We try to get to as many as we can, but as you know, we may not be able to in the time. So, if you still have questions, we'll provide you with next steps and places to go to get those answers. With that, I will turn it over to my colleague Elizabeth Holland.

>> Thank you, Ashley. Next slide. So, we're going to start with a quick overview of the Merit-based Incentive Payment System, or MIPS. MIPS is a part of the Quality Payment Program that was created by the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA. Your participation in MIPS will determine your payment adjustments to your Medicare Physician Fee Schedule payments. In 2017, MIPS will be replacing the Physician Quality Reporting System, or PQRS, Value Modifier, and Medicare EHR Incentive Program for eligible professionals. Please note that the Medicare EHR Incentive Program for hospitals and the Medicaid EHR incentive program still will continue to exist. MIPS has four components, and today's presentation is going to focus on the Advancing Care Information and Improvement Activities performance categories.

Next slide, please. So, what are the performance category weights? There are specific weights assigned to each category. You'll see, quality is 60%, and for 2017, or the transition year, cost is weighted at 0. Improvement activities have 15%, and Advancing Care Information is 25%.

Next slide, please. So, who can participate in MIPS? MIPS-eligible clinicians are considered physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetists. In addition, you must be a Medicare Part "B" clinician who bills more than \$30,000 a year to Medicare and are providing care for more than 100 Medicare beneficiaries.

Next slide, please. Non-patient facing clinicians. So, these are clinicians who are eligible to participate in MIPS as long as they meet other criteria, such as exceeding the low-volume threshold, and they're not newly enrolled or are not in a qualifying APM. A group would be considered a non-patient facing group if greater than 75% of the NPIs, the individual NPIs that are billing under the group's TIN during a particular performance period are labeled as non-patient facing. There are also special reporting requirements for non-patient facing. We will be releasing the codes that will determine whether a particular MIPS-eligible clinician is non-patient facing, and that will be available soon.

Next slide, please. Who is excluded from MIPS? So, clinicians who are newly enrolled in Medicare. When you first enroll in Medicare, in our Provider Enrollment System, you'll be exempt from reporting on measures and MIPS during the following performance year from whenever you registered. Clinicians who are below the low-volume threshold -- and that means if your allowed charges are less than or equal to \$30,000 or if you see less than 100 Medicare beneficiaries -- you're considered below the low-volume threshold and therefore excluded from MIPS. And also if you are significantly participating in Advanced Alternative Payment Models.

Next slide, please. So, in the transition year, which is 2017, you are able to pick your pace. And there's really four options under Pick Your Pace. Under MIPS, you could be not participating, which means that you didn't send any 2017 data. And if you don't send us any data, you will receive a negative -4% payment adjustment. You could also choose a test pace, and this gives you an opportunity to experiment with the program. Clinicians must submit some data. And then you can earn either a neutral or a small payment adjustment. For partial years, clinicians report for a period of 90 days

within the calendar year of 2017. For full year, you would report for the entire calendar year. And the MIPS payment adjustments are based on the data submitted. So the best way to get the maximum MIPS payment adjustment is to participate for the full year. And when you participate for a full year, you get the most measures to choose from and you will have more reliable data submissions. So we're encouraging people to pick the best participation pace that's best for them, although full-year reporting will help you prepare for the future.

Next slide, please. So, I'll give you a little bit more information about each. If you pick your pace and decide to test for 2017, you need to submit something. And there's defined what that means. You can either submit one quality measure or one improvement activity or either four or five of the Advancing Care Information measures. That depends on what your EHR technology is certified for. So, for example, if you're using EHR technology certified to the 2015 edition, you would submit the five required base measures.

Next slide. For partial participation, you would submit 90 days of data. And this would allow you to earn a positive payment adjustment. But it would be expected that you would report more than one quality measure and more than one improvement activity and minimum months of base score for the Advancing Care Information performance category.

Next slide. For full participation, you would report for the full year, and that would maximize your chances to qualify for a positive payment adjustment. You're also eligible to be considered an exceptional performer. And so, during the beginning of the program, there's additional dollars set aside, so in addition to earning up to a 4% positive payment adjustment, you could also earn an additional amount for being an exceptional performer. And so full participation would be reporting six quality measures and reporting either on four medium-weighted or two high-weighted improvement activities and reporting the base Advancing Care Information measures and some performance measures.

Next slide. In addition, you have the option, under MIPS, to report as an individual or as a group. If you report individually, you report under your individual Tax Identification Number. As a group, that means there's more than two clinicians that are billing under a single TIN, and so it's important to note that you have to choose whether you're going to submit as an individual or a group for all the performance categories. You can't choose to submit as an individual for some performance categories and submit as a group for others. You have to make that initial determination for yourself.

Next slide. So, when you're participating in MIPS, you need to get your data to CMS. And we're providing many options for submitting data. So, once you've made your determination whether you're going to submit as an individual or a group, then you need to stay within either the left column, which is for individuals, or group. And then you'll submit your data for each of the three performance categories. You need to choose one option per category. So, for example, for quality, you could choose to submit your data via QCDR. But for Advancing Care Information, you don't have to submit via QCDR. You can choose to attest to your data. So you make the data-submission choice on a per-category basis.

Next slide, please. So, when does MIPS actually start? The first performance period starts January 1st of 2017 and continues through the entire calendar year of 2017. We will gather the data in early 2018, and the payment adjustment -- either positive, neutral, or negative -- will be effective in calendar year of 2019.

Next slide. Now we're going to go on and do a deeper dive into "Advancing Care Information and Improvement Activities" performance categories.

Next slide, please. Advancing Care Information. So, who can participate? All MIPS-eligible professionals. And you can participate as an individual or group. Some professionals will be optional in 2017. For example, hospital-based MIPS-eligible clinicians, nurse practitioners, physician assistants, clinical nurse specialists, and CRNAs. Others, like skilled nursing facilities, nursing homes, et cetera, are not eligible under MIPS at all.

Next slide. So, the Advancing Care Information category promotes patient engagement and electronic exchange. Many eligible clinicians may be familiar with the components of Advancing Care Information performance category because it is very similar to the Medicare EHR Incentive Program. The measures that are in the Advancing Care Information measure set are based on stage 3 of the EHR Incentive Program. The 2017 Advancing Care Information transition objectives and measures are based on the modified stage 2.

Next slide, please. So, in order to participate and earn an Advancing Care Information score, you need to have certified EHR technology. The measures that you select are going to be based on the version of the EHR technology that you have. So, if you're using EHR technology certified to the 2015 edition, you can report on the Advancing Care Information objectives and measures. If you have EHR technology certified to the 2014 edition, you can report on the 2017 Advancing Care Information transition objectives and measures.

Next slide. So, for Advancing Care Information for the transition year, or for 2017, if you're doing the test pace -- that's where you submit something and you're choosing to submit Advancing Care Information, you need to either submit the four or five base score measures. Full participation would be submitting more than the base scores. So you would need to submit some performance measures.

Next slide, please. So, here we have what's considered the base scores. These are the required measures. If you're doing Advancing Care Information, which means you have certified EHR technology that's certified to the 2015 edition, you would have five required measures. If you're doing the 2017 transition objectives and measures -- that's if you have EHR technology certified to the 2014 edition -- you have four measures to report on. So, as you'll see, for both of these measure sets, a security risk analysis is one of the measures. So, if you were to answer "no" to security risk assessment, you would get a zero for that and you would not earn any points For Advancing Care Information. For the other objectives and measures here, you would be submitting a numerator and a denominator. The denominator must be at least 1. And so, just as a reminder, if you do not fulfill the base score, you will not be able to earn a performance score or a bonus score.

Next slide, please. So, these are the measures that are the Advancing Care Information performance measures. You will notice that in the "Measure" columns for both of the measure sets, some of these have little asterisks. That means that those particular measures were included in the base score, but you could also earn a performance score for submitting a numerator and denominator for those particular measures. And you'll also note that, for the Advancing Care Information objectives and measures, there's actually nine measures. And for the 2017 transition measures, there are seven measures.

Next slide. So, there's also the opportunity to increase your score further by submitting bonus measures. If you report to one of the public-health or clinical-data registry reports' reporting, you could earn an additional 5% bonus. And you would earn that 5% bonus if you do one of the additional reporting or more than one. And so syndromic surveillance reporting is available for those who are using 2015- or 2014-edition EHR technology. Specialized registry reporting is only available for those who are using EHR technology certified to the 2014 edition. And electronic case reporting, public-health registry reporting, and clinical-data registry reporting are all available for those who are using the EHR technology certified to the 2015 edition. And in order to achieve a score on this, you need to have reached one of the three levels of active engagement for public-health reporting. And the first one is completed your registration to submit your data electronically. The second option is testing and validation. And the third option is you're actually in production, which means you're sending data electronically to a public-health or clinical-data registry on an ongoing basis. In addition, there's another opportunity to earn a bonus score of 10% if you're using certified EHR technology to report certain improvement activities.

Next slide. So, this slide just illustrates the selected improvement activities that would earn you that additional 10% bonus. And it doesn't matter if you select a high or a medium factor. Fulfilling any of these would earn you the 10% bonus under the Advancing Care Information.

Next slide, please. So there is additional flexibility for Advancing Care Information. So, we mentioned before that hospital-based MIPS-eligible clinicians and clinicians who lack face-to-face interaction, and nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists would be automatically reweighted. And what that means is that the 25 points for Advancing Care Information will be reallocated to the quality category. However, if any of those categories choose to report and submit data, then that data will be scored, and it will not be reweighted. So you will have to really think carefully about whether, if you fit one of those criteria, if you're going to submit data or not. Additionally, you can apply to have your performance category reweighted to zero if you submit an application for reweighting. And you can submit an application for reweighting if the following conditions apply -- either you had insufficient Internet connectivity, you suffer from extreme and uncontrollable circumstances, or you have a lack of control over certified EHR technology. We will be releasing more information about how to submit an application for reweighting in the coming weeks.

Next slide, please. So, as I mentioned, hospital-based, eligible clinicians can qualify to be automatically reweighted. I want to point out, though, that the definition of "hospital-based" is a little different than it was under the previous EHR Incentive Program. The definition of "hospital-based" under MIPS if you have 75% or more of your Medicare services performed either in the inpatient, the on-campus outpatient department, or the emergency department. Those are place-of-service 21, 22, or 23. We will reweight the category to zero and assign that 25% to quality. But then again, if you are submitting data, then we will score that data and we will not reweight the category for you.

Next slide. So, scoring, because I talked about, under Advancing Care Information, that there's a base score, a performance score, and a bonus score. In order to calculate what your 25% would be, we will add the base score, the performance score, and the bonus score. Now I'm going to let Angela give us an overview of improvement activities, and then, after that, we'll go into scoring more in detail.
Angela?

>> Thank you, Elizabeth. I'm Angela Foster. I'm a health-insurance specialist here at CMS, working on improvement activities. We are on slide 27, looking at the improvement activities performance category. I know it'll be new to most clinicians. This category is worth 15% of the clinician's final score and assesses how much a clinician participates in activities that improve clinical practice. For example, these activities include how well a clinician share in decision-making with a patient, also how the clinician improves patient safety, coordinates care, and increases access for patients. The improvement-activities category also includes incentives that help drive presentation and certified patient-centered medical homes and alternative payment models. Clinicians will have flexibility to choose from approximately 90 activities. I believe we have 93 total now under nine subcategories. These include expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, participation in an advanced payment model, achieving health equity, integrating behavioral and mental health, and emergency preparedness and response.

Slide 28, please. Please note that clinicians will receive a zero as their improvement-activities score if they do not participate in an APM, a certified patient-centered medical home, or a medical-home model, and they do not report any activity.

Slide 29, please. So, now let's take a look at the flexibilities that are afforded to you in the improvement-activities category. Since it will be new to most clinicians, there will be many questions around the requirements. The improvement-activities category requires that no clinician or group has to report more than four activities. Additionally, there are special considerations for practices with 15 or fewer clinicians, rural or geographic health-professional shortage areas, non-patient facing, APMs, and certified medical homes. Practices with 15 or fewer clinicians, rural or geographic HIPSAs, and non-patient facing would be able to choose one of the following combinations to get the total score for this category. They can one high-weighted activity or two medium-weighted activities.

Slide number 30, please. Beginning January 1, 2017, CMS will begin recruiting participants for a study aimed at reducing the burdens associated with data submission for quality measurement. The aim of the study is to examine the current process of clinical workflow and data capture by different data-submission processes, to understand what causes burden within different physician groups. Also to make recommendations to influence change that will attempt to eliminate the burden, to improve quality data capture and reporting, as well as enhance clinical care and ultimately evolve a design of clinical quality measurement. There will be a minimum of 42 PQRS-eligible -- I'm sorry, not PQRS -- of eligible professional groups, as stated by MIPS criteria, from the following seven categories: 10 urban individual or groups of less than three eligible professionals, 10 rural individual or groups of less than three eligible professionals, 10 group practices of three to eight eligible professionals, also five group practices of eight to 20 eligible professionals, three group practices of 20 to 100 eligible professionals, two group practices of 100 or greater eligible professionals, as well as two specialty groups.

Slide 31, please. Now we will move into the scoring methodology for Advancing Care Information and improvement activities. I will now pass the presentation back to Elizabeth.

>> Thank you, Angela. Next slide, please. So, scoring for Advancing Care Information. This represents 25% of your total score. The base score makes up 50% of your 25% total, so that the base score is essentially equal to 12.5. You must submit a numerator/denominator or a yes/no for each of these measures, whichever measures that you choose. Failure to meet the recording requirements will result in a base score of zero. And if you have a base score of zero, you will not be able to earn a performance

or base score. So, for example, the first measure there, a security risk analysis, if you answer "no," you will earn a base score of zero. For all the other measures, you need to have a numerator of at least 1 when you submit your numerators and denominators.

Next slide, please. Next, we move to the performance score. The performance score is based on the performance measures that you choose to submit. So, if you choose to submit on one or two, we would add the scores from those two measures together to result in your performance score. So, for example, if a yes/no measure, like immunization registry reporting, if you answer "yes," you will get 10%. For everything else, your score is based upon the numerator and denominator that you submit.

Next slide, please. So, to explain this a little more, your performance rate is based on the numerator and denominator that you submit. As you'll see, if you submit, For example, a numerator of 850 and a denominator of 1,000 for, let's say, the secure-messaging measure that would equate to a performance rate of 85. And if you look at the chart on the left-hand side of the screen, an 85 would give you 9%. So, if you submitted three other measures, for example, we would add those rates together to get your total performance score.

Next slide. The bonus score is pretty straightforward, where you would earn 5% if you report on one or more of the registry measures. And if you use certified EHR technology to report on activities in the selected improvement-activities list, you will receive a 10% bonus.

Next slide, please. So, how do we arrive at your final score? Remember, it's 25% of the total MIPS score. The base score will give you 50% of that score. The performance score, you'll get up to 90%. And the bonus, the 5% and the 10% together would be 15%. And you'll notice that adds up to 155, which is way over 100. So, if you earn 155, that's great, but you only need to earn 100. If you earn 100, you will receive the full 25% for the Advancing Care Information category. Now I'm going to turn it back over to Angela.

>> Thank you, Elizabeth. Now we're going to take a look at MIPS scoring for improvement activities. Earlier, we discussed that the improvement-activities performance category score was comprised of a selection of activities that were deemed either medium-weighted or high-weighted. Let's discuss the points assigned to each weight. Activities with a medium weight are worth 10 points each. Activities with a high weight are worth 20 points each. The maximum allowable number of points that clinicians may earn in the improvement-activities category is 40 points. There is one very important distinction to note within the category for clinicians who are in small practices, rural practices, practices in health-professional shortage areas, and non-patient facing roles. The number of points assigned to each weighting are different for these specific clinicians. Medium-weight activities are worth 20 points each, while high-weight activities are worth 40 points each. And remember, clinicians who practice in a patient-centered medical home, a medical-home model, or similar specialty practice automatically receive full credit for the category.

Slide 38, please. Now that we have an idea of how the points will be distributed, let's take a look at the category calculation. The improvement-activities category score equals the total number of points earned for completed activities, divided by the total maximum number of points. So it would be 40 times 100. Slide 40, please. Sorry, I skipped a slide.

Slide 39, please. Sorry about that. When calculating the final score, CMS will multiply the score for each performance category by the assigned weight of the category. Then, CMS will add the weighted scores

to derive a value between zero and 100. The equation logic is as follows: The final score equals the clinician quality-performance category score times the actual quality-performance category weight, plus the clinician cost-performance category score times the actual cost-performance category weight, plus the clinician improvement-activities performance-category score times the actual improvement-activities performance-category weight, plus the clinician Advancing Care Information performance-category score times the actual Advancing Care Information performance-category score, times 100.

Next slide, please. Elizabeth will now help us look beyond the transition year.

Elizabeth? -I think it's Ashley. -Oh, I'm sorry, it's Ashley. Moving it on to Ashley.

>> No problem. Thanks, Angela. So, next slide, please. So, thinking beyond the transition year. Because this is the first year of the program, but, obviously, we want to continue to build on a user-centric approach, and with that, we are always willing and open to accept, receive, and hear feedback from you. And so we included our Partnership mailbox on this slide because we are interested in partnerships with organizations, to help get information out at more of a grassroots kind of boots-on-the-ground level. We know that, oftentimes, that clinicians work very closely with medical societies and associations, and so we would love to partner with many of those associations and societies to further get you the information that you need. So, what you see there is the Partnership mailbox. And just looking at some of the feedback that we're looking forward to hearing about, one being implementation of virtual groups, which, as you know, will not be implemented for the transition year but for the further years. And so we're interested in getting feedback. More to come on some of the different venues that we'll have in place to receive feedback, but that is on the table.

Next slide, please. So, the next slide gives some high-level areas, or topic areas, for where we are looking for your feedback again.

Next slide, please. And so, then, slide 43 now gives you the details of where to go and how to officially submit your comments for policy. So, we, obviously, accept questions and we answer those questions on webinars. And if you call the help desk or our service center, we can definitely provide you with answers. If you would like to officially comment on some of the policy, the way to do that would be via the mechanisms listed on slide 43. You can submit your comments via those mechanisms through December 19th, so that is approaching, next week, next Monday. So you still have a little time if you would like to give us some official comment on the policy for 2017.

Next slide, please. So, the next section of slides, you'll see basically outlined technical assistance that we have right now. So, if you could advance to slide 45, please. We have technical assistance that these folks are ready and willing to help. There is criteria for the different helpers or organizations on the ground. And so we do have that listed. One is that we have the portal, so many of you, I'm sure, have used it to register for this webinar, for instance. Transforming Clinical Practice Initiative, ready and willing to assist. We also have our QIN-QIOs. So, the Quality Innovation Networks, they are also ready and willing to assist. And in addition, the Innovation Center, which, here at CMS, supports the APM's work, if you have a learning system in place, to help those that are developing and already in APMs, needing assistance. So, those hyperlinks will take you to the individual Web pages to get more information for that.

Next slide, please. So, again, this is just a follow-up slide with all of the mechanisms that I just mentioned -- the technical-assistance folks that are in place and willing and ready to help.

And the next slide, 47, just gives you some instruction on Q&A. And so, with that, I will end here. Again, we will try to answer as many questions as we can. And for those that we aren't able to answer, we do have the Web address up there that goes directly to our service center, and they will also work to get your questions answered. So, I will turn it back over to Stephanie and the team for Q&A.

>> Thanks, Ashley. So, we have a number of questions in the queue. And, Elizabeth and Angela, I'll start to read them. And I'll read them aloud, and you can say your answer aloud for everyone to hear. The first question is, "How is Advancing Care Information scored for hospital-based and non-patient facing clinicians who are part of a large multi-specialty TIN reporting as a group?"

>> That would depend on whether they choose to submit their data or not. They still have the option, because they're hospital-based, or the group has the option, to include their data or not, because they're hospital-based. So it's the same as if they were reporting individually. They could choose to report or not.

>> They will be scored as a group practice. So whatever the group score is, after reporting, that will be applied to all clinicians within the group. And so, thus, the score, whatever the update is, will apply to everybody in the group.

>> Okay. Thank you. Next question is, "Will Medicare still publish a physician fee schedule?"

>> Yes, on an annual basis.

>> Okay, the next question is, "When ACI is set to zero in certain instances, to what category is the percentage applied?"

>> It is, the entire 25 points are moved to quality category. So, instead of being 60, it would be 85.

>> Okay. The next question, "My EHR vendor is not ready for MIPS. What is their deadline to be up and running?"

>> So, I'm not sure I understand that. You can submit using either your EHR technologies that certify to the 2014 edition, or I'm assuming the question is assuming they're not ready for the 2015 edition. But you can use whatever EHR technology you already have in place.

>> Okay. The next question, "Will it be possible for a clinician to report ACI data in multiple separate instances? For instance, a clinician may report as part of their group and then, later, in the same year, the clinician might choose to report individually. The final will indicate CMS will take the highest score in such a scenario." Is that correct?

>> Yes, it is.

>> Hi. So, I think that question, we would refer that question to the service center.

>> Okay.

>> Thank you.

>> Sure. The next question, "Do you meet the 'achieving health equity' measure seeing Medicaid patients?" Hang on a minute. I'm going to read this again. "Do you meet the 'achieving health equity' measure seeing Medicaid patients if you seek dual eligible but not patients with Medicaid only?"

>> Are you talking about an improvement activity? Activities aren't measures, so I just want to make sure that I'm understanding.

>> I believe they are referencing the improvement activities. I can go to the next question.

>> Okay.

>> "If we choose the Pick Your Pace options, do we report one patient for a minimum of one day, or for one day for all patients that day? Also, must one day or one patient be submitted through the QR -- through a qualified registry?" Do you want me to say that again?

>> Hi. I'm sorry. We're just taking a moment to reflect on that question.

>> Sure.

>> We're going to need to actually refer that question to the service center, please.

>> Okay. There are a few questions about the attestation system and if providers will be submitting their data for ACI and IA into the same system for EHR.

>> No, they won't be submitting to the same system. There will be a new system for MIPS. However, if you are an eligible clinician that's still participating in the Medicaid EHR Incentive Program, you would need to attest to Medicaid if you're still eligible to earn an incentive to participate in the EHR Incentive Program, but there will be a new system for MIPS, that's not yet available.

>> Okay, thank you. Next question, "For physicians, clinicians who have never reported in meaningful use and would be exempt for ACI in the first year, how does reporting scoring work if they are part of a larger group?"

>> Sort of like how we handle hospitals.

>> Well, it's the same as if they were hospital-based. They can choose to report, and then they'd be scored, or they don't have to report for that first year. It's up to the group to determine whether they want to include their data or not.

>> Okay, thank you. And this may be similar, Elizabeth, but the question is, "When reporting as part of a group, will P.A.s and N.P.s will be excluded from ACI scoring if no data is submitted?"

>> Yes, they won't be included in the score, but if they're part of a group, they would get the same update as the group.

>> Okay. Okay, next question. "Are midlevel providers, nurse practitioners, physician assistants who are not eligible For the Medicare meaningful-use program required to attest to ACI under MIPS in 2017 and beyond?"

>> No, they don't have to attest in 2017. They can choose to if they wish to, but they are not required in 2017.

>> Okay. The next question is, "When will the requirements for improvement activities be published?"

>> The improvement activities are available on our QPP website. You can review them there. And all of the language for what is considered "required" is there.

>> Okay. Thank you. There are a couple questions related to eligibility and the thresholds, asking for clarification around the \$30,000 threshold and the 100-patient threshold. So it might be a good idea to review that again.

>> Okay. So, in terms of who is excluded from MIPS?

>> Yes.

>> Clinicians who are newly enrolled or clinicians that are below the low-volume threshold. So, that would be Medicare charges of less than or equal to \$30,000 a year or if they see 100 or fewer Medicare Part "B" beneficiaries in a year.

>> Thank you. The next question, "Does an eligible clinician need to inform CMS in advance if they will be attesting as an individual or a group? If so, how do they do this?"

>> They do not have to inform. They just need to submit their data.

>> This is Alex Mugge. Just to add on to that, the only time that a group practice would need to inform us that they are participating as a group is if they intend to report through the Web interface for their data submission or if they intend to report the caps data as part of their submission. And there will be registration system available for group practices that intend to utilize those two options. Information on how to register will be available in advance of that portal becoming live.

>> Okay. Thank you, Alex. Next question. "We are a MIPS APM, and we must submit one year of quality data. For ACI, can we submit for 90 days, or do we need to submit a full year, as that is what we're required to do for quality data?"

>> For the APM.

>> We'll have to refer that to our help desk.

>> For the APM portion.

>> Okay. There's a question about whether or not there will be an FAQ page on the QPP site.

>> An FAQ page?

>> Yes. Yes.

>> So, I think -- this is Ashley -- there is future plan to build out frequently asked questions, and how we deliver that is still in question. So the short answer is, yes, we are looking to do that. The long answer is that it most likely will not look like what we have currently on cms.gov. So it will be something different. And so that is in the works.

>> Thanks, Ashley. Next question, "For the test portion of Pick Your Pace, which allows for one improvement activity to receive credit, we can we pick any improvement activity, or do we need to pick a high or medium activity as indicated on the QPP site?"

>> You can pick a medium activity. It will get you the 7.5 points toward your final CPIA score. You're not required to pick as many activities as you would need to get to the total 40 points to get you the 15%. But if you chose the medium, that's going to get you only half of that total score for the improvement-activities performance category. I just want to make sure that that's clear.

>> Okay.

>> Thank you.

>> So, while you're teasing out a question, I just wanted to say -- this is Ashley again -- is, looking in the chat, I see that we have a handful of questions related to the Pick Your Pace option and what do they look like, what does that mean. Just to reiterate that on the MIPS overview webinar that happened -- and those slides are posted -- that you will find detailed information on the transition year. And we really tease out what Pick Your Pace means for each performance category and what it looks like to test partially or fully participate in each one. So I do want to kind of point back to that resource for all of the listeners today.

>> Thanks, Ashley. Next question, "If we do not use an EHR, we obviously cannot submit data for ACI. Do we have to attest or submit to this fact anywhere?"

>> No.

>> Okay.

>> You would just not complete that portion of your MIPS reporting.

>> Okay. Thank you. Next question, "Can you clarify what the maximum possible points are for the ACI category?"

>> Well, in terms of the percentage of the MIPS total score, it's 25 points out of the MIPS total score. However, when you're adding up the base and the performance and the bonus, the maximum score is 155, which is capped at 100. So if you were to earn, for example, 125, you would get 100, and that would equal 25 points For the Advancing Care Information category.

>> Okay. Thank you, Elizabeth. Next question, "In the rule, it states that the performance for ACI for groups will be based as a group score. Does that mean the report showing numerator/denominator now has to be combined, or can it still be for all eligible clinicians within the group?"

>> I'm sorry, I could not hear the question.

>> I'm sorry. Can you hear me now?

>> Yeah, that's better.

>> "In the rule, it states that the performance for ACI for groups will be based as a group score. Does that mean the report showing numerator/denominator now has to be combined, or can it still be for all eligible clinicians within the group?"

>> The attestation, the data that is submitted for the ACI category should be aggregated for the group. So there should be one submission for the group, with one numerator/denominator per measure or yes/no statement per measure for the entire group.

>> So that does mean that if a group is using multiple EHR technologies, they have to sum the measures numerators and denominators across different EHRs, because it needs to be the total for the group.

>> Thank you. Next question, "If you do group reporting, you only need a 1 in the numerator for the entire group to get credit for the base For under ACI?"

>> Correct, yes.

>> Thank you. Next question, "When will the specifics of the improvement activities be released? The wording on the 90-plus activities are vague or may be subject to interpretation."

>> We are not planning to issue any more specific language around the activities for the transition. We kept it simple, and for the reason that we're just doing a simple adaptation. We aren't requiring any specific data to be submitted. So, for the transition year, what you find on the QPP website for the improvement-activities description is all that we're issuing at this point for the transition year.

>> Thank you. I'm sorry, I'm just scrolling with the next question. "Do we have to report mixed measures for 50% of all payers, or just Medicare Part 'B'?"

>> Do you think that's a quality question?

>> Okay, do you want me to take another one?

>> And for Advancing Care Information, it's all patient.

>> In general, for all categories, you can report on all patients. In terms of the percentage threshold for the quality measures, that's a quality-scoring question, as in how many you have to report on to meet each measure.

>> Thank you. The next question, "5% of what number per Advancing Care bonus, and 10% of what number for CEHRT? Will this be a one-time payment as with meaningful use?" Does that make sense, Elizabeth? Let me know if you need me to clarify.

>> I think what it's going to be is a combination, so that whatever score you get in the MIPS will be applied to your Physician Fee Schedule payment amounts. It will update your fee schedule amounts, but the added bonus for the exceptional performers, that's still being worked out how those payments will be made.

>> Thank you. Next question, "For ACI, will the exclusion for meaningful use for eligible professionals that write fewer than 100 prescriptions in a reporting period apply to the ACI measure?"

>> No.

>> Okay. Next question, "Under ACI, you will not get partial credits -- For example, 5.34. Could you get 7.5%, or do you only get full points?"

>> Full percentages.

>> Right, no partial ones.

>> You do get 8 or 9, right, not 7.5.

>> Okay, thank you. This person asks, "Please clarify again, if the nurse practitioners, P.A.s, CNSs, CRNAs, or non-patient facing ECs will be reporting improvement on their activities under the alternative activity weight, they still need to have a total of 40 points to get the full 15% for improvement activities, but their medium activity is worth 20 points, and high is worth 40 points. Is that correct?"

>> That is correct.

>> Thank you. Next question, "If I am excluded due to low volume, will we be assessed with a negative-4%, or will we maintain as negative?"

>> Could you repeat?

>> I think the question is asking, "If you are excluded, will you receive an adjustment -- a negative payment adjustment?"

>> If you're excluded because you're reweighted for Advancing Care Information? Hold on just a second.

>> Okay.

>> You can answer.

>> So, if the question is, "If you're excluded from MIPS, do you get a negative payment adjustment?" that is not correct. You don't get a negative payment adjustment if you're excluded from MIPS.

>> Thank you. Next question, "For benchmarks being calculated in the performance year, how many entities monitor their performance for the quality measures?"

>> Unfortunately, this is a call that is focused on Advancing Care Information and improvement activities, so we're going to have to refer the quality questions to our call center.

>> Okay, thank you. Next question, "What if your CEHRT year changes midyear due to an upgrade, and you're submitting a full year's worth of data? Which option should we choose?"

>> You can submit a combination. You can aggregate your data between the two EHRs and submit the data together for the Advancing Care Information category. So, if this is a question strictly for the Advancing Care Information, you would be able to, since you're trying to submit the full year, even if you change midyear, you could add the numerators and denominators from your previous EHR to your new EHR, and submit the data as one submission. Now, that's different than for quality-measure reporting. That data-aggregation process, if you intend to report the electronic clinical quality measures, eQMs that are specified for an EHR, for that data-aggregation process, you would not simply add together the numerators and denominators. You would work with a data-aggregation vendor to combine that data and submit, again, one submission for the full year.

>> Thanks, Alex. Next question, "Are the performance portions of quality and ACI going to be scored against benchmarks, or will you decide performance score directly, correspond to percentage performance -- i.e., 95% performance equals 9.5 points?"

>> For Advancing Care Information, it is related to the numerators and denominators that you submit, so that if you were to submit the performance rate -- in my example of a numerator of 850 and a denominator of 1,000, that would give you a rate of 85, and that would correlate to 9%.

>> Thank you. Here's another scoring question For ACI. "For the ACI bonus score, is it just the flat 5% bonus of the total category score?" Oh, no, I'm sorry. The question moved.

>> So, the bonus for Advancing Care Information is applied to that 155 percentage that Elizabeth was talking about earlier. So you can earn a certain amount, up to 140%, by reporting the base and performance score, and then you can earn up to 15% with the two bonus opportunities, for a total of 155%, which would be capped at 100 and then applied to the total possible points -- the 25 points available for ACI. So, if you get 100, you get 100. You get the 25 points. Or if you get anything above 100, you're capped at those 25 points, still.

>> Okay. Thank you, Alex. Next question, "Does MIPS reporting take the place of EHR reporting? Do we still have to use a qualified EHR, or can we do claims-based reporting?"

>> So, the data needs to come out of your EHR. Still, for Advancing Care Information, it would still be the same sort of reporting that you would do under the EHR Incentive Program, where the data has to come out of your EHRs. The numerators and denominators will come out of the EHR.

>> If the question is about -- and sorry, just because we're not clear on what the question relates to, I'll just add this additional information in case anybody is curious. For quality-measure reporting, if the question was about submitting quality measures and whether claims measures are now acceptable,

there's no quality-measure component of the Advancing Care Information performance category, so you no longer are required, like you were under the EHR Incentive Program, to submit electronic clinical-quality measures in order to earn credit. In the quality category, you could, instead, report by a claim or one of the other reporting mechanisms -- registry, QCDR -- and that wouldn't work against you for the Advancing Care Information performance category.

>> Thank you, Alex.

>> It could confuse people further.

>> Okay, next question. "For measures that change or were added in the middle of a year -- for example, in 2016 -- will CMS use historical 2016 benchmarks or performance year 2017 benchmarks? For example, last year, Measure 145 changed, Measure 436 was new, and this year, Measure 359 changed."

>> So, again, that's a quality question, and we'll refer that to our Quality help desk.

>> Okay. Sorry about that, Elizabeth. Next question, "For the performance score for ACI, please explain how we would score for patient education, which is 10%. Please explain in detail. Numerator is 100, and denominator is 1,000?"

>> Okay.

>> So, if you had a numerator of 100 and a denominator of 1,000 that would equal...

>> It would be .1.

>> .1, and so...

>> You would earn 1% with that.

>> ...that would earn 1%.

>> Thank you.

>> Okay.

>> Sorry, I'm just reading questions here. Next question, "Do we report on every single Medicare patient at each visit in order to get the highest score, and on only one Medicare patient at one visit to get the lowest score?" You may have already answered this. Can we clarify how many Medicare patients you need to report on per measure?

>> There's no limit for the number of Medicare patients you have to report on per measure. In general, you have to report on Medicare patients as part of the data that you submit, and make sure that Medicare is one of the payers that you are submitting data on. And then, for the different performance categories, there are different requirements for how much of your patient population has to be included in what you are reporting.

>> And then, to piggyback on that, that would also be covered in the MIPS overview slide. So, when we talk about the transition year, we do talk about data completed for the different categories, so that information would be included.

>> Okay, thanks, Ashley. Next question, "Slide 34 says that each of the performance measures are worth 10% to 20%. How can you get more than 10%?"

>> It's all based on your numerator and denominator that you submit.

>> And just to further expand on that, for the Advancing Care Information objectives and measures, each of those measures is worth up to 10%, so you could earn 1% up to 10%. For the 2017 transition measures, because there are fewer measures of the measures that we have upweighted, a couple of the measures could be up to 20%, so you would earn over the 10% if you were reporting on those particular measures and you earned a performance rate that would get you that 20%.

>> So, for example, one of the transition measures that's worth 20% is providing patient access. That's a 20%. So is health information exchange. And that's mainly because, under the Advancing Care Information measures, health information exchange is actually split into two measures. So, when you have EHR technology certified to the 2015 edition, you're able to report on the two measures that are each worth 10%. But when you have the EHR technology certified to the 2014 edition, it's just one measure for health information exchange, so it's worth 20%. The total is always going to be the same. The scores for whichever measure that you choose will always sum to 155. You will not be disadvantaged by whatever measures that you choose to report on.

>> Okay, thank you. We've received another question. "How do you report improvement activities to CMS?"

>> I'm sorry. You said, "How would you report them?"

>> Yes.

>> We are looking at providing attestation via a CMS website that is currently under production, so that will become available soon. You can also report via QCDR through your EHR.

>> Thank you. Next question, "Will improvement activities be published on the Physician Compare website? If so, what information will be published?"

>> I will have to refer that question to the service center.

>> But I think all of the MIPS scores will be posted on the Physician Compare website. So the scores will be.

>> Okay, thank you. Next question, "Can you report as a group under MIPS if not all of your providers are using CEHRT?"

>> Yes.

>> Okay, thank you. Next question. You briefly touched on this before. You sort of answered this. "Are mid-levels and non-patient facing eligible clinicians exempted only for ACI and other performance categories, including I.A. and Q.M.?"

>> They're only excluded for the Advancing Care Information performance category.

>> Okay, thank you. Next question, "Several responses have stated that when part of a group, P.A. and N.P. must report data on the Advancing Care Information category. Can you clarify with certainty that if P.A. and N.P. are part of a group, that we have the option to not report data for them, and have the ACI category be weighted to zero for P.A./N.P.?"

>> Well, if they're reporting at the group level, we won't reweight. Their data is just included, but you don't have to submit data for them.

>> Okay. Thank you, Elizabeth. "When doing group reporting -- For example, for ACI, for transitions of care -- must the numerator equal the denominator? For example, if, for 400 providers under group reporting, we have 5,000 visits as the denominator, must the numerator equal 5,000 for the number of transitions of care? Or if there is at least one TOC for the 400, we would get credit?"

>> For the base score measures, all you need is a 1 in the numerator. If you are reporting a measure as a performance measure, you would report whatever your actual numerator would be, and that would equate to your score for that particular measure.

>> Thank you, Elizabeth. Next question, "What is the minimum reporting period?"

>> Well, it really depends on which pace you choose. If you're reporting, for example, one quality measure, you need to just report on that one quality measure. One improvement activity, it's one improvement activity. There isn't a reporting period linked to it. It's just submitting data.

>> Thank you. "For the test option for Pick Your Pace, which allows for one improvement activity to receive credit, can we pick any improvement activity, or do we need to pick a high or medium activity?" I think you may have already answered that. Sorry about that.

>> Yes, I answered this question earlier. And you can pick either a medium or a high, but you have to keep in mind that the medium is worth half of the total score for the category. So, if you pick a medium, you will get 7.5 points towards your final score. But if you pick a high, then you would get the full 15 points.

>> But you could report either one, and avoid the negative payment adjustment by submitting data.

>> Okay, thank you.

>> I'm sorry. I was actually, in my mind, gearing that to the special considerations, like the small practices and the rurals. The points would be different if you were not one of those special considerations. So you would have... I'm getting myself confused. Disregard what I just said. Sorry.

>> Okay. Next question, "If your group decides to collect data for the first 90 days of 2017, and a clinician joins later in the year, will he still be covered in the group's reporting year, even if the data is not reflective of that individual's performance?"

>> You're not going to be able to report till January of 2018. So you can choose whatever period within 2017 you want, but you won't be able to report until later.

>> Okay, thank you. Next question, "Do you get the 10% bonus for each improvement activity done with CPIA, or does one activity get you the same bonus of three?"

>> The one activity would get you the same bonus as three.

>> Okay, thank you.

>> You're limited to 10%, regardless of how many you submit.

>> Okay. Thank you. Next question, "Since CPOE is not a measure for ACI, the related requirement to have medical-assistant credentials by an outside organization, for the purpose of successful participation in CMS quality programs, will also be eliminated in 2017. Is that correct?"

>> Correct that CPOE was eliminated, but I don't know. Sorry, we don't understand the rest of the question.

>> Okay. Next question, "Do we still need to attest to eCQMs as part of ACI attestation?"

>> No, the quality-measure component that existed under the EHR Incentive Program is not continued in the Advancing Care Information performance category. So all you need to report on are the Advancing Care Information measures for that performance category. Quality measures are submitted separately, and they won't impact your Advancing Care Information score.

>> Okay, thank you. Next question, "What type of documentation is required for improvement activities?"

>> So, for improvement activities, we're not exactly requiring documentation, but what we are telling providers is that you should retain copies of medical records, charts, reports, and any electronic data utilized, to determine which measures and activities were applicable and appropriate for their scope of practice, and patient population for reporting under MIPS for up to 10 years after the conclusion of the performance period, to prepare for verification in the event that you're selected for an audit. This record-retention timeframe aligns with the record-retention timeframes already in place for the APMs, either established in regulation or included in participation agreements. CMS may request any records or data retained for the purposes of MIPS for up to six years and three months. And we will provide audit specifications through subreg. guidance. And MIPS-eligible clinicians or groups selected for data-validation audits will be provided instructions and examples of documents required.

>> Okay, thank you, Angela. Next question. And I think we'll answer this question and then do one more or two more questions. "We are a specialist and are exempt from sending summary of care, because we do not refer to other physicians. What should we do in 2017?"

>> Sorry, just one second, please. There may have been an exemption under the EHR Incentive Program, but there's no such exclusion under Advancing Care Information.

>> Okay, thank you. And then the final question, "Will providers be told whether they are considered under one of the flexibility categories for improvement activities?"

>> You will be able to... Well, what we're gearing towards is for you to be able to enter your information into the CMS website that would determine what your eligibility would be.

>> Okay, thank you. And I think actually that will conclude our Q&A portion.

>> Thank you so much for everyone joining today and hanging on as long as you could to get the questions answered. Thank you again for completing the closing poll. We did get a pretty good response rate from that. One thing to mention -- and I said it at the top of the webinar -- is that we will also have a similar webinar for the quality-performance category and the cost-performance category. They will be joined in the same Format as this webinar was today. So, please stay tuned. We should have the registration link for those up in the next week or so. And then you will be able to register for the webinar, which will take place in mid-January. That's all I have today. Thank you all for joining.

>> Thank you. This concludes today's conference. You may now disconnect. Speakers, hold the line.